PRINTED: 10/02/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		17E531	B. WING _			10/	02/2015
	ROVIDER OR SUPPLIER	cu		60	TREET ADDRESS, CITY, STATE, ZIP CODE 17 COURT PL AKIN, KS 67860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	000 INITIAL COMMENTS		F	000			
F 248 SS=D	the health resurvey of 483.15(f)(1) ACTIVIT INTERESTS/NEEDS The facility must provof activities designed the comprehensive a	TIES MEET	F2	248			
	by: The facility reported The sample of 16 res for activities. Based of and record review, the	a census of 38 residents. sidents included 3 reviewed on observation, interview, he facility failed to provide an aram for 1 (#12) of the 3 or activities.					
	the resident admitted following diagnoses i (progressive mental of failing memory, confu- degeneration of the re- deterioration of the re-	disorder characterized by usion), and macular etina (progressive etina).					
	10/14/14, revealed the provide information, revealed the resident The resident required	nimum data set), dated ne resident was unable to and the staff assessment tenjoyed listening to music. It total assistance with g, and was not ambulatory.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		17E531	B. WING _			10/02/2015
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F 248	Continued From pag	e 1	F 2	48		
	10/17/15 revealed th communicate effective	re area assessment), dated e resident was not able to vely. The family visited often oyed 1 to 1 conversation, and				
	resident preferred to activities, and the resactivity preference we music, and 4th grade complete an activity to determine interest of physical and/or me invite the resident to	wed on 7/29/15, revealed the participate in group sident's specific individual as visits, aromatherapy, a readers. Staff would assessment at least annually s, taking into consideration ental limitations. Staff would activities, and assist the e during the activities.				
	the resident napped resident 's current in social events, radio,	nent, dated 7/23/15, revealed regularly during the day. The sterests were music, parties, reading, spiritual, grooming, conversing, volunteer visits,				
	to 9/30/15 revealed t	y progress notes from 6/9/15 he resident attended an during the time frame				
		M, the resident remained in vation revealed the room c, or a television.				
	stated the resident di and stated he/she us	PM, direct care staff I, id not go to many activities, sed to have a soothing music he music box was now sident 's room.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 248	F 248 Continued From page 2		F 2	48			
F 274 SS=D	the resident would list the sound machine w room, and did not know activity preferences who is the resident has his/her room, but it was department, and exploration to keep the resident did attend some music proportion attend card playing there was nothing in the activities for the resident did stated the resident did attend some music proportion attend card playing there was nothing in the activities for the resident did stated the resident did attend some music proportion attend card playing there was nothing in the activities for the resident mis/her room for activities/her room for activities/her room for activities in any activities activities in any activities for the resident mental, and psychosometric participate in any activities for the resident mental, and psychosometric participate in any activities for the resident mental, and psychosometric participate in any activities for the resident mental, and psychosometric participate in any activities for the resident mental, and psychosometric participate in any activities for the resident mental, and psychosometric participate in any activities for the resident participate for participate in any activities for the resident p	3 AM, social service staff D, id a sound machine in as now kept in the activity ained there was no available dent's room at this time. PM, direct care staff J, denjoy music, and would rograms, but the resident did g. Direct care staff J stated he resident's room for ent. PM, administrative nursing ould put a sound machine in ity, and staff used to take the resident was unable to vities. Policy for activities for the dependent residents of the rovide an ongoing activity itively impaired resident, to 's highest level of physical, ocial well- being. PREHENSIVE ASSESS	F 2	74			
30 0	A facility must conduc						

[` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	(X3) DATE SURVEY COMPLETED		
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F 274	facility determines, of that there has been a resident's physical or purpose of this section means a major declir resident's status that itself without further itimplementing standa interventions, that had one area of the resident requires interdisciplir care plan, or both.) This REQUIREMENT by: The facility reported with 16 selected for robservation, interview facility failed to assess for significant changes. Findings included: Resident #38's phy 9-8-15, included diagon (progressive mental failing memory and copsychosis (any major characterized by a gresting), peptic ulcer (backflow of stomach depression (abnormatic characterized by exasadness, worthlessness	dent within 14 days after the r should have determined, a significant change in the mental condition. (For on, a significant change he or improvement in the will not normally resolve intervention by staff or by rd disease-related clinical is an impact on more than ent's health status, and harry review or revision of the access of 38 residents, eview. Based on a vand record review, the is 2 residents (#38 and # 2) in status. The instantial disorder characterized by confusion) with unspecified mental disorder characterized by confusion) with unspecified mental disorder coss impairment in reality disease, esophageal reflux a contents to the esophagus), all emotional state gagerated feelings of ess, emptiness and anxiety (mental or emotional disorder charactery (mental or emotional disorder).	F 274			

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F 274	Continued From page	e 4	F	274			
		nt's medical record, revealed ed to acute care on 8-21-15 acility on 9-8-15.					
	8-21-15 assessed the cognitive impairment, inattention and disorg wandering behavior, assistance with dress assistance with bed reating, and personal continent of bowel an required limited assis have swallowing or d documented a height weight of 139 pounds loss. The resident red medications daily and medication during the The Nutrition CAA (ca 8-21-15 advised staff regular diet and could	with fluctuating times of ganized thinking. He/she had required extensive sing and toilet use, limited nobility, transfer, walking, hygiene, and was always d bladder. The resident tance to eat and did not ental problems. The record of 60 inches and current without or unknown weight eived antidepressant d 1 day of antianxiety e 7-day observation period. The area assessment dated the resident received a diffeed him/herself.					
	resident needed assi- could feed him/herse advised staff the resident of bowel and bladder reposition the resident directed staff the resident assistance of one staff	nt in bed every 2 hours. It dent could ambulate with ff and a gait belt for short deeded to propel the resident					
		on 9-29-15 at 8:42 a.m. t down beside the resident					

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F 274	drank 540 cc (cubic depisodes of coughing bites of fruit loops. The a glass of water, but to his/her mouth, at wistraw for the resident staff B revealed the reassistance with eating. Observation, on 9-29 direct care staff T and resident away from the bathroom. The reside and started to have a incontinence brief. Interview on 9-29-15 care staff T revealed of bowel and bladder. Interview on 9-30-15 administrative staff C decline in several are should have completed MDS. The facility lacked a proposition of the facility failed to complete the facility failed to compl	dent to eat. The resident centimeters) of fluid with after swallowing, and a few he resident attempted to hold could not to bring the glass which time staff B obtained a highlight in the sident required staff g could no longer walk. 1-15 at 12:29 p.m. revealed did direct care staff U took the he dining table to use the ent was incontinent of urine a bowel movement in the late 12:30 p.m. with direct the resident was incontinent of the revealed the resident did has of daily living and staff end a significant change coolicy to assess the resident has complete a significant change hen resident #38 declined in g.	F 23	74			
		#2's signed admission revealed the following					

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F 274	disorder characterize confusion), coronary (CAD-abnormal cond of oxygen to the hea urinary tract infection Review of resident #	e (progressive mental ed by failing memory and artery disease dition that may affect the flow rt), chronic pain, and chronic	F 2	74		
	revealed he/she had mental status) of zer impairment. The resi communication diffic behaviors or delirium one staff for transfer- his/her room. Furthe required extensive a toilet use. He/she had	a BIMS (brief interview for o, indicating severe cognitive dent did not have any ulties. He/she exhibited no and required supervision of s and walking in and out of r review revealed he/she ssistance of one staff for d occasional bladder ff used a bladder training				
	had short and long-to- confusion and deper (activities of daily living the confusion and deper (activities of daily living the confusion of th	2/s Urinary Incontinence CAA dat times he/she could alert to use the bathroom. Further the did not alert anyone after ence. He/she did not his/her adult incontinent d incontinence and did not him/herself, or even throom was. Further review heterventions were in effect to				

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F 274	revealed staff were to go to the bathroor Further review reveal continent of bladder him/herself, therefore the resident. The carused incontinent properties as possible and odo him/her with toileting needs after each incomplete him/her clean him/her clean him/her clean him/her clean him/her he/she had a bowel/assist with changing reveled staff were to bowel movements, to toilet every 2 hours of after meals, 3-4 times staff assist with hygical Review of resident #9/15/15 revealed no cognition, ability to complete ADL (activities of dain had bladder incontinual Review of the nurse 8/12/15 revealed state been exhibiting increasing, and combativative revealed the resident for breakfast, very litted drink adequate fluid. Review of the nurse 8/21/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse 9/16/15 revealed state difficulty swallowing Review of the nurse	o care plan for resident #2 o ensure he/she did not have in before assisted to activities. Aled resident #2 wanted to be and bowel but could not toilet it e staff were to offer to toilet ir e plan revealed resident #2 ducts to keep him/her as dry ir free. Staff were to assist in needs, provide hygiene continent episode, to help ierself each shift and when bladder accident, and to his/her pads. Further review immonitor and document all io assist resident #2 to the during the day, before and ies at night, and provide 1-2 iene and toileting. E2's quarterly MDS dated change in the resident 's communicate, behaviors, or fily living) and he/she always ence. physician report dated iff reported the resident had eased confusion, episodes of the behaviors. Further review at had refused to eat anything the for lunch, and did not physician report dated iff reported the resident had	F 274				

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 274	9/22/15 revealed sexhibited rigidity a down. Staff further staff placed the rewheelchair. Observation on 9/AM revealed reside wheelchair in the care staff AA properthe activity room a transfer the resided. To prompted him/howithout any obvious appropriate hygien buttocks looked not redness. The brief resident remained. Observation on 9/direct care staff U resident #2 to the and provided a gastoilet where the reby staff. Further or removed a dry addresident. During an interview care staff B report decline since admitted to the incontinent individualized to illegical to the incontinent individualized to illegical to the staff.	se physician report dated staff reported the resident had and had difficulty bending to sit reported due to rigidity the sident in a hight back 29/15 from 7:20 AM until 9:37 lent remained seated in his/her dining room. At 9:37 AM direct elled him/her to the restroom in and provided gait belt assist to ent to the toilet. Direct care staff er to urinate and he/she did, us problems. Staff T provided the care and resident #2's formal without any areas of f staff removed from the	F2	274			

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F 274	possible. Staff B furth previously had a procapproximately 18 mousing it. Staff B reportshould be completed. During an interview of care staff P reported difficult to understand be toileted every 2 hours the resident had a drone wet brief per his/stated resident #2 vo. During an interview of care staff H reported had worsened since 10/3/15) and he/she of resident #2 did not ta prompted. Staff H repincontinent episodes H further reported the after his/her tooth ext stopped talking after he/she reported all definition in the promoted but used shingles. Staff R furth mouth pain and require reported staff assiste every 2-3 hours, before During an interview of Administrative staff Co.	rmal bladder function as the reported the facility theses in place, but on this ago, the facility stopped ted voiding assessments every year for residents. In 9/30/15 at 3:39 PM, direct resident #2 had been and that he/she needed to burs. Staff P further reported by brief most of the time with the shift. Staff P further ided when prompted. In 9/30/15 at 4:05 PM, direct resident #2's incontinence his/her shingles diagnosis declined. Staff H reported lik much, but urinated if the ported the resident had more when he/she had pain. Staff the resident had a lot of pain reaction (6/11/15) and that time. Staff H stated eclines in ADLs to the nurse. In 9/30/15 at 4:29 PM In R reported resident #2 had a the toilet more before the reported resident #2 had a red a soft diet. Staff R and him/her to the restroom the supper, and before bed. In 9/30/15 at 5:02 PM In reported resident #2's	F2	274			
		a lot since arriving at the d the resident had weight					

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F 274	loss, UTIs, and teeth significant change d significant change a completed. Review of the RAI m change (either declinated residents condition foccurred, as indicated resident's current state comprehensive assequarterly assessment is not expected to reweeks, indicated a sassessment should. The facility failed to MDS assessment after areas of the resident resident #2. 483.20(c) QUARTEI LEAST EVERY 3 Minuments and approved by CN once every 3 months. This REQUIREMENT by: The facility census included in the samp record review, the facompleted a quarter	n extracted and verified a id occur. Staff C verified a sesessment should have been manual revealed a significant ne or improvement) in a from his/her baseline that ed by comparison of the latus to most recent ressment and any recent not and the resident's condition of turn to baseline for two dignificant change be completed. Conduct a significant change for a decline in 2 or more to physical functioning for the sessment and significant change for a decline in 2 or more to physical functioning for the sessment and significant change for a decline in 2 or more to physical functioning for the sessment and significant change for a decline in 2 or more to physical functioning for the sessment and significant change for a decline in 2 or more to physical functioning for the sessment as a resident using the rument specified by the State of the sessment as evidenced as a resident sessment and the ses	F 274			

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F 276	Findings included: Review of resident (minimum data set) of he/she had a BIMS (stats) of 0, indicating impairment. He/she or behaviors. The resided mobility, transfer and corridor. The resided antibiotics during the Review of resident #7/16/15, revealed he cognition, behaviors, living) ability from the 1/13/15. Resident #2 antidepressant mediobservation period. Review of the resided 1/13/15-7/16/15 revealed he/she went assessments. Interview with adminat 9:22 AM, revealed responsibility for confor the facility, aroun quarterly MDS needer reported he/she did in completing a quarter he/she went in to colassessment in July 2 According to the RAI Instrument) Manual 3	#28 's quarterly MDS dated 1/13/15, revealed brief interview for mental a severe cognitive exhibited no signs of delirium sident was independent with rs, and walking in the room sident received daily cation and 3 days of 7-day observation period. 28 's annual MDS dated /she had no change in or ADL (activities of daily exprevious assessment on the received antipsychotic and cations daily during the 7-day ant 's MDS record from the relative nurse C, on 10/1/15 the/she had the expleting MDS assessments did April, 2015, at the time the the ded completed. Staff C contrealize he/she missed by MDS on time, when explete the annual control contr	F2	276			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 276	quarterly assessment		F	276			
F 280 SS=D	resident #28. 483.20(d)(3), 483.10(PARTICIPATE PLANI	k)(2) RIGHT TO NING CARE-REVISE CP	F	280			
	incompetent or other incapacitated under the	ne laws of the State, to g care and treatment or					
	within 7 days after the comprehensive assessinterdisciplinary team physician, a registere for the resident, and disciplines as determ and, to the extent prathe resident, the residegal representative;	e plan must be developed e completion of the ssment; prepared by an , that includes the attending d nurse with responsibility other appropriate staff in ined by the resident's needs, cticable, the participation of lent's family or the resident's and periodically reviewed in of qualified persons after					
	by: The facility reported with 16 selected for reobservation, interview facility failed to review	is not met as evidenced a census of 38 residents, eview. Based on a and record review, the a and revise the plan of care ning for 1 (#26) of the 16					

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F 280	Continued From page	≥ 13	F 2	280				
	Findings included:							
	the resident as cognit assistance of 1 with be indicated the resident choose a tub bath or a daily living, dated 11-resident required assis was able to make his known, to make choice he/she desired. The care plan, revised	dated 11-13-14, documented tively intact and needed pathing. The assessment at felt it was very important to shower.						
	cueing and physical a	assistance for activities of depreterences for bathing						
	Observation, on 9-28- the resident with facial growth.	-15, at 11:08 am, revealed al hair of several days						
	am, revealed the resid	ident, on 9-28-15 at 11:08 dent received a shave when h was twice a week, but the shaved daily.						
	the resident awake in	-15 at 10:30 am, revealed the room, reclining in bed, al days of facial hair growth.						
	Interview, on 9-30-15	at 10:30 am, with the						

ND DLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	17E531	B. WING _		,	10/02/2015	
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280 Continued From page 14 resident, revealed the rescaused itching, and he/sh shaved. The resident state attempts to shave with the difficulty getting close end shave. The resident state scheduled to receive a bastaff became busy or he/missed the baths and the was also missed. Interview, on 9-30-15 at 3 administrative nursing state resident stayed up late at during the morning and we facility until dusk, and the should be revised to inclubabits, and change the bound the facility lacked a policiplan. The facility failed to revie and grooming care plan to preferences for daily shawer reviewed for resident schedule. F 309 SS=D HIGHEST WELL BEING Each resident must receiprovide the necessary care or maintain the highest pomental, and psychosocial accordance with the comand plan of care.	sident felt the facial hair ne would like to have it ated he/she did make e electric razor, but had ough to get a smooth ed he/she was ath in the evenings, but she was outside and assistance with shaving assistance with shaving assistance with shaving assistance with shaving as in and out of the ought the care plan and the resident's ath time to late night. By on revision of the care we and revise the bathing to ensure the resident's ving and bathing times and preferences and daily as in and services to attain racticable physical, I well-being, in	F 2				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	COMPLETED		
		17E531	B. WING		10/02/2015		
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	10/02/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION		
F 309	Continued From pa	ge 15	F 30	9			
	by: The facility reporter The sample of 16 re reviewed for skin or observation, intervie facility failed to mor the 3 sampled resid Findings included: The electronic ch admitted on 8/26/14 including; chronic o inflammatory disease characterized by va symptoms, reversib bronchospasm) and from an excessive a body tissues). The annual MDS (n 9/2/15, revealed the interview for mental intact cognition. The with ADL's (activity with a wheelchair. The with ADL's (activity with a wheelchair. The issues and receive medication. The CAA (care area for ADL's revealed oriented and indepe aware of safety need	ew, and record review, the nitor a bruise for 1 (#31) of lents. art revealed resident #31, 4, with the following diagnoses betructive asthma (chronic se of the airways riable and recurring ple airflow obstruction and diedema (swelling resulting accumulation of fluid in the minimum data set) dated expression resident had a BIMS (brief a status) score of 15, indicating expression was independent of daily living), and was mobile the resident did not have skin did an anticoagulant assessment), dated 9/10/15, the resident was alert and endent in ADL's, and was					

	ND PLAN OF COPPECTION IDENTIFICATION NUMBER		(X2) MULTIP	LE CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED		
		17E531	B. WING		1	0/02/2015		
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 309	integrity daily. Review of the skin and thru 29/15, lacked do to the left arm. On 9/28/15 at 11:38 addeep blue discoloration forearm approximated on 9/29/2015 at 1:24 stated the bruise occur run into the wall or the scooter, because the very well going throughous happened a fewent to get some coff on the door frame who doorway. The resider his/her arm the other remember which day	d wound report from 9/1 cumentation of any bruising am, observation revealed a on to the resident's left y 3 by 2 inches in diameter. PM, direct care staff I, urred because he/she would be door frame with his/her resident did not slow down by the doors. PM, the resident stated the w days ago when he/she fee and brushed his/her arm ile backing out of the st stated a nurse checked day, but could not	F 30	,				
	stated when a skin pr would measure the w findings in the skin ar nurse progress note. On 9/30/2015 at 3:22 staff C, stated the nur measure and docume on the bruise daily un	ent the skin injury and chart til it was resolved. The nily would be notified of skin						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E531	B. WING			1	0/02/2015	
	ROVIDER OR SUPPLIER	U		607	EET ADDRESS, CITY, STATE, ZIP CODE COURT PL KIN, KS 67860			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 309	should complete a sk admission and weekl quarterly, and with a	s Prevention of Skin ted 4/2010, revealed staff in integrity assessment on y for 4 weeks, then significant change.	F:	309				
F 311 SS=D	483.25(a)(2) TREATM IMPROVE/MAINTAIN A resident is given the services to maintain of		F	311				
	by: The facility reported with 16 selected for re observation, interview facility failed to provide	v and record review, the le grooming and bathing s desired for 1 (#26) of the						
	Findings included:							
	the resident as cognit assistance of 1 with b indicated the resident choose a tub bath or	dated 11-13-14, documented tively intact and needed pathing. The assessment telt it was very important to						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E531	B. WING		10/02/2015
	ROVIDER OR SUPPLIER	cu		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 311	resident required ass was able to make his able to make choices desired. The care plan, revise resident desired indecueing and physical daily living. Observation, on 9-28 the resident with faci growth. Interview with the resam, revealed the resident desired to book observation, on 9-30 the resident awake in and noted with sever literview, on 9-30-18 resident, revealed the caused itching, and is shaved. The resident attempts to shave will difficulty getting close shave. The resident scheduled to receive staff was busy or head the baths and the as missed. Interview, on 9-30-18 resident scheduled to receive staff was busy or head the samissed.	e-14-15, assessed the sistance with showering and sher needs and wants know, and go to bed when he/she are defendence but needed staff assistance for activities of all hair of several days sident, on 9-28-15 at 11:08 and hair needed as shave when the was twice a week, but the ended have a week and hair growth. So at 10:30 am, revealed hair growth. So at 10:30 am, with the ended he/she would like to have it hat stated he/she did make the the electric razor, but had be enough to get a smooth stated he/she was a bath in the evenings, but she was outside and missed sistance with shaving was	F 31 ²		
	care staff I, revealed	the evening shift provided esident, but if the resident			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E531	B. WING	B. WING		10/	02/2015
	ROVIDER OR SUPPLIER	U		6	TREET ADDRESS, CITY, STATE, ZIP CODE 07 COURT PL AKIN, KS 67860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 311 F 312 SS=D	staff Z, revealed the rand then miss the bar stated the resident dibath on 9-28-15. Interview, on 9-30-15 administrative nursing resident stayed up lat during the morning arfacility until dusk. The facility lacked a pactivities of daily living. The facility failed to passistance with bathin desired by the resided 483.25(a)(3) ADL CADEPENDENT RESID. A resident who is una daily living receives the state of the part of the state	at 3:30 pm, with direct care esident would go outside thing opportunity. Staff Z d not receive the scheduled at 3:30 pm, with g staff C, revealed the eat night, and then slept in and was in and out of the colicy on grooming and g needs. rovide an opportunity for any and shaving as often as ant. RE PROVIDED FOR		311			
	and oral hygiene. This REQUIREMENT by: The facility reported residents sampled in personal hygiene nee interview and record provide adequate ass	is not met as evidenced a census of 38. The 16					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E531	B. WING		10/02/2015
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LTC	eu		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 312	hygiene, including #2 #33 with oral hygiene Findings included: - Resident 22 's quadocumented A BIMS Status)and the reside assistance with dress hygiene needs. The care plan, review lack of staff guidance removal. The reside independent as poss staff cueing and or pl dress self with minimare to assist with sho Review of the reside medical record), reversident received a b the resident received a b the resident received shaving on the night Review of the resider resident scheduled to Mondays and Saturd On 9/29/2015 a 7:18 dressed for the day, shedroom. Closer obs on the resident was furt hair which remained	for for provision of personal 22 with facial shaving and 22 with facial shaving and 32 eneeds. Arterly MDS, dated 8/13/15, 36 (Brief Interview For Mental ent required extensive sing, toileting, and personal aved on 8/11/15, revealed the 32 for the resident's facial hair and would like to be as 32 ible with ADLs but may need 34 hysical assistance, is able to 34 assist from staff, and staff owers 2 times weekly. And the same as a standard of the 3/28/15, and also that 3/28/15. And the resident, revealed the 3/26/15. And the resident, fully 3/28 in the recliner in his/her 3/28 in the recliner in his/her 3/28 in the recliner in his/her 3/28/15 in the recliner in his/her 3/	F 31.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		E SURVEY PLETED	
		17E531	B. WING _			10	/02/2015	
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	explained the resider supposed to be shaw the least, with showe to shave him/her, as do this him/herself. Sfacial hair grows very keep it shaved off. The facility failed to expression of the suppose of the same of the suppose of t	PM, direct care staff L, nt 's facial hair was ed every other day, and at the resident was unable to staff L added, the resident 's y quickly and the staff try to ensure this dependent equate assistance for	F	312				
	sheet dated 12/9/14 diagnoses: osteoarth to one or many joints and pain), hypocalce blood), dementia (pro characterized by faili and chronic pain. Review of resident #	#33's signed physician order revealed the following ritis (degenerative changes characterized by swelling mia (low calcium in the ogressive mental disorder ng memory and confusion), 33's comprehensive MDS assessment dated 12/22/14						

	(X3) DATE SURVEY COMPLETED	
17E531 B. WING 10/02	2/2015	
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
revealed he/she had short and long-term memory problems, and severely impaired cognitive skills for daily decision making. Further review revealed he/she required extensive assist of one staff for personal hygiene. The MDS revealed he/she had no dental issues. Review of the quarterly MDS dated 9/14/15 revealed resident #33 had short and long term memory problems and severely impaired cognitive skills for daily decision making. Further review revealed he/she required extensive assistance of one staff for personal hygiene. The MDS further reveled he/she had no dental issues noted. Review of the CAA (care area assessment) for dementia dated 12/22/14 revealed resident #33 was dependent on staff with limited to extensive assistance for all his/her ADL (activities of daily living) cares. The CAA further revealed resident #33 had a history of dementia with short and long-term memory loss with confusion, mood disorders, anxiety, and agitation. Review of the 12/16/14 care plan revealed he/she had physical and or mental limitations that could affect his/her ablility to perform ADLs. The care plan further revealed staff were to assist him/her to maintain good grooming and personal oral hygiene. Further review revealed the resident had his/her own teeth. Staff were to help him/her to clean his/her teeth/mouth twice a day and as needed. Review of the oral care documentation from 7/1/15-9/30/15 revealed the resident received oral care daily, not twice daily as care planned.		

AND DI AN OF CORRECTION IDENTIFICATION NUMBER	DING (X3) DATE SURVEY COMPLETED
17E531 B. WIN	³ 10/02/2015
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU	STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860
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Observation on 9/29/15 at 11:08 AM revealed direct care staff T and direct care staff U provided oral care with an oral swab. He/she did not resist cares. Interview with direct care staff T on 9/29/15 at 11:13 AM revealed staff provide oral care twice a day, once upon waking and once before bed. Staff T further stated he/she used an oral swab on the resident. Interview with direct care staff P on 9/30/15 at 3:44 PM revealed staff provided oral cares and staff were aware he/she had partials to be cleaned. Staff P stated the resident was very good at brushing his/her teeth. Interview with direct care staff U on 9/30/15 at 11:53 AM revealed staff used an oral swab for his/her oral cares and staff never used a toothbrush. Interview with licensed staff S on 9/30/15 at 11:58 AM revealed the facility had no formal system in place for oral assessments. Interview with licensed staff R on 9/30/15 at 4:43 PM revealed the direct care staff performed oral cares for the resident. Staff R further stated direct care staff would use toothbrush and toothpaste for all residents, even with dentures. Interview with administrative staff C on 9/30/15 at 5:23 PM revealed the staff should have used a toothbrush, but it depended on resident preference. Review of the Dental Care policy dated 6/2009 revealed on admission the facility staff would	= 312

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) DATE SURVEY COMPLETED	
		17E531	B. WING			10/	02/2015
	ROVIDER OR SUPPLIER	U	•	STREET ADDRESS, CITY, 607 COURT PL LAKIN, KS 67860	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	the need for further d should receive daily o highest level of oral h The facility failed to m	or previous dental work and ental needs. Each resident oral care to ensure the ealth and oral function.	F	312			
F 315 SS=D	and provide oral care 483.25(d) NO CATHE RESTORE BLADDER	ETER, PREVENT UTI,	F	315			
	resident who enters to indwelling catheter is resident's clinical concatheterization was now who is incontinent of treatment and services.	ity must ensure that a					
	by: The facility reported The sample included observation, interviev facility failed to ensur assessment and inter residents reviewed for	a census of 38 residents. 16 residents. Through w, and record review the e staff provided appropriate eventions to ensure 1 of 2 or urinary incontinence normal bladder function as #2.					
		#2's signed admission revealed the following (progressive mental					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
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F 315	disorder characterize confusion), coronary (CAD-abnormal cond of oxygen to the hear urinary tract infection. Review of resident #2 (minimum data set) a revealed he/she had mental status) of zero impairment. The resid communication difficute behaviors or delirium one staff for transfers his/her room. Further required extensive as toilet use. He/she had incontinence and staff program. Review of the Demer assessment) dated 6 had short and long-teconfusion and depen (activities of daily livir. Review of resident #2 CAA dated 6/5/15 revalert staff he/she nee Further review reveal anyone after he/she had provide hygiene for hremember where the	d by failing memory and artery disease iition that may affect the flow t), chronic pain, and chronic (UTI). 2's comprehensive MDS assessment dated 6/5/15 a BIMS (brief interview for p), indicating severe cognitive dent did not have any ulties. He/she exhibited no and required supervision of a review revealed he/she asistance of one staff for di occasional bladder ff used a bladder training and the could ded upon staff for ADL and the could ded to use the bathroom. 2's Urinary Incontinence area ded to use the bathroom. 2's Urinary Incontinence area ded incontinence. He/she did and incontinence and did not incontinence and did not	F3	315				
	Review of the 6/2/15	care plan for resident #2						

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		17E531	B. WING			10/	02/2015
	ROVIDER OR SUPPLIER	cu	Ì	607	REET ADDRESS, CITY, STATE, ZIP CODE COURT PL KIN, KS 67860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	to go to the bathroom Further review reveal continent of bladder a him/herself, therefore the resident. The car used incontinent prod as possible and odor him/her with toileting needs after each inco him/her clean him/her he/she had a bowel/t assist with changing revealed staff were to bowel movements, to toilet every 2 hours of after meals, 3-4 time staff assist with hygie Review of resident # 9/15/15 revealed no cognition, ability to co ADL (activities of dail had bladder incontine The 6/10/15 care pla provide good hygiene episode and monitor care plan on 8/18/15 UTI and a goal the U or less with antibiotic Review of bladder ar documentation from resident had an aver- episodes and 2 conti-	be ensure he/she did not have a before assisted to activities. led resident #2 wanted to be and bowel but could not toilet be staff were to offer to toilet be plan revealed resident #2 ducts to keep him/her as dry afree. Staff were to assist needs, provide hygiene continent episode, to help be staff each shift and when coladder accident, and to his/her pads. Further review to monitor and document all to assist resident #2 to the during the day, before and as at night, and provide 1-2 ene and toileting. 2's quarterly MDS dated change in the resident 's communicate, behaviors, or by living) and he/she always ence. In revealed staff were to be after each incontinent skin daily. Staff updated the revealed the resident had a TI would resolve in 20 days is given as ordered.	F	315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		17E531	B. WING _			10/02/2015	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 315	Continued From pag	e 27 ram or a voiding diary.	F 3	315			
	Review of nurses no	tes from 6/1/15- 9/30/15 ntation regarding bladder					
	AM revealed resident wheelchair in the din direct care staff proping the activity room a transfer the resident him/her to urinate an obvious problems. So hygiene care and resonormal without any a	tremained seated in his/her ing room. At 9:37 AM two elled him/her to the restroom nd provided gait belt assist to to the toilet. Staff prompted d he/she did so without any taff provided appropriate sident #2's buttocks looked reas of redness. The brief, he resident remained dry.					
	direct care staff assis restroom in his/her w gait belt assisted tran resident urinated upo	115 at 4:02 PM revealed 2 sted resident #2 to the rheelchair and provided a nafer to the toilet where the on prompting by staff. Further staff removed a dry adult the resident.					
	care staff B reported decline since admiss the facility did not ha assess the cause for for the incontinence pindividualized toiletin residents of the specimaintain as much no possible. Staff B furth previously had a prograpproximately 18 mo	on 9/30/15 at 11:34 AM direct resident #2 had a general ion. Staff B further reported we a system in place to the incontinence, monitor pattern, and/or develop g plans for incontinent ial care unit (SCU) to rmal bladder function as mer reported the facility cess in place, but onths ago, the facility stopped ted voiding assessments					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		· ,	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 315	should be completed During an interview of care staff P reported in difficult to understand be toileted every 2 hours the resident had a dry one wet brief per his/listated resident #2 void buring an interview of care staff H reported had worsened since in (9/3/15) and he/she did resident #2 did not tall prompted. Staff H reported the after his/her tooth extra after that time. Staff High declines in ADLs to the During an interview of licensed nursing staff incontinence but used shingles. Staff R furthmouth pain and requireported staff assisted every 2-3 hours, before During an interview of Administrative staff C status had changed a SCU. Staff C reported loss, UTIs, and teeth significant change did staff did not establish	every year for residents. In 9/30/15 at 3:39 PM, direct resident #2 had been and that he/she needed to ours. Staff P further reported by brief most of the time with her shift. Staff P further ded when prompted. In 9/30/15 at 4:05 PM, direct resident #2's incontinence his/her shingles diagnosis eclined. Staff H reported k much, but urinated if orted the resident had more when he/she had pain. Staff is resident had a lot of pain raction and stopped talking if stated he/she reported all he nurse. In 9/30/15 at 4:29 PM In R reported resident #2 had at the toilet more before her reported resident #2 had red a soft diet. Staff R at him/her to the restroom re supper, and before bed. In 9/30/15 at 5:02 PM In eported resident #2's lot since arriving at the at the resident had weight extracted and verified a loccur. Staff C verified the	F3	315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E531	B. WING		10/02/2015	
	ROVIDER OR SUPPLIER	:u		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 315	Review of the facility Urinary Incontinence residents who were in receive appropriate to prevent urinary tract much normal bladder Further review revea residents would be effected and a 72 consecutive completed. A call to resident #2's 9:32 AM was unsucce physician's office star out of the office for the The facility failed to perform the continence as possib 483.25(h) FREE OF HAZARDS/SUPERV The facility must ension environment remains as is possible; and ear	policy on Management of dated 6/2008 revealed noontinent of bladder would reatment and devices to infections and to restore as function as possible. Ited the policy stated valuated upon admission a hour voiding diary would be so physician on 10/1/15 at essful. Staff at the ted the physician would be the week. Provide an individualized maintain as much bladder ole for resident #2. ACCIDENT ISION/DEVICES	F 323			
	by: The facility reported Based on observation	r is not met as evidenced a census of 38 residents. n and interview, the facility esidents ' environment				

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E531	B. WING		10/02/2015	
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си	607	REET ADDRESS, CITY, STATE, ZIP CODE 7 COURT PL IKIN, KS 67860	1 10142	
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F 323	remained as free of by the failure to ens functioning system of impaired, independent wandering outside of 13 residents were or independently mobile. - Observations on importing of 9/28/15 exit doors were unloalarm system. On 9/29/15 at 7:17 at 100 hall door locate care unit hallway downen opened. An observation on 9 the 100 hall exit door alarm. During an interview licensed nursing stareset the alarm whe 100 hall alarm but it reset the alarm agained "15" (meaning pushing on the door door would open) at On 9/29/15 at 10:04 reset the 100 hall al make a noise. Staff	accident hazards as possible ure the exit doors had a to prevent cognitively ently mobile residents from of the facility. Per facility report organitively impaired and let. Initial tour of the facility on the revealed the 100 and 200 hall ocked without an activated at the end of the special or alarmed appropriately Initial tour of the facility on the revealed the 100 and 200 hall ocked without an activated at the end of the special or alarmed appropriately Initial tour of the facility on the revealed without an activated at the end of the special or alarmed appropriately Initial tour of the facility on the revealed without an activated at the even alarm to the dath the end the unuses on the stated the nurses on it went off. Staff S reset the did not lock the door. Staff in and the electronic displaying after 15 seconds of the with the alarm sounding the end the door locked. In a.m. licensed nursing staff S arm and stated it did not S used a key and reset the	F 323			
	pushing on the door door would open) and On 9/29/15 at 10:04 reset the 100 hall all make a noise. Staff alarm. The door the alarm voice stated t	with the alarm sounding the nd the door locked. a.m. licensed nursing staff S arm and stated it did not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED		
		17E531	B. WING	 	1	0/02/2015	
	ROVIDER OR SUPPLIER	cu		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	(elopement preventionear the door. It was electronic display look two red dashes show Staff S stated this show a "15" showing above the door and significant push open the diseconds. During an interview of maintenance staff Y any problems with the not know what would buring an interview of maintenance staff Y on each hall function electronic display look indicate "15". The open area (not encloopened to a fenced-alarms were checked Staff Y also stated stope sure the "15" direcommended the displayment of the sure the "15" direcommended the displayment of the sure the "15" direcommended the displayment of the sure the sure the sure facility had a policy ficonfirmed the exit do equipped with a Warrow During an interview of care staff H stated it resident tried to get of the sure of the staff of the sure staff H stated it resident tried to get	aring a WanderGuard on bracelet) must have been a pointed out to staff S the cated above the door just had ving and the door opened. Sould not happen, but shoulding on the electronic display staff should not be able to cor without waiting the 15. On 9/29/15 at 12:31 p.m., stated the facility never had be 100 hall exit door and did a cause the alarm to turn off. On 9/30/15 at 9:30 am, explained how the exit doors led, and that the redicated above the door must 200 hall door opened to an ised) while the 100 hall door in area. Staff Y stated the diveckly by maintenance, aff should check the doors to isplayed. Staff Y cors be checked every shift. The point of the cord on monitoring. Staff Y cors in question were not	F 32	3			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		17E531	B. WING		10/02/2015
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 323	administrative nursing policy for checking the WanderGuard brace function. At 5:18 p.m a fire drill staff would doors and reset the power surge occurrent staff needed to be traincidents. The facility does not exit doors to make suproperly. The facility failed to functioning system to deficient, independent wandering outside of potentially hazardout.	on 9/30/15 at 4:30 p.m. ng staff C stated there was no ne door alarm system but elets were checked weekly for n., staff C stated if there was I have to manually lock the alarms. Staff C stated a ed on the weekend and that ained on how to handle such have a policy on testing the ure they are working ensure the exit doors had a to prevent cognitively ntly mobile residents from if the facility unsupervised into s places. NUTRITION STATUS	F 32		
SS=D	Based on a resident assessment, the factor resident - (1) Maintains accept status, such as body unless the resident's demonstrates that the (2) Receives a thera nutritional problem.	's comprehensive ility must ensure that a table parameters of nutritional weight and protein levels,			

PRINTED: 10/02/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		17E531	B. WING			10/02/2015	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325	with 16 selected for robservation, interview facility failed to provid (#36 and #37), of 3 re loss, to prevent weight Findings included: - Resident #37 's ph 9-8-15, included diag progressive mental difailing memory, confurction psychosis (any major characterized by a greating), peptic ulcer of (backflow of stomach depression (abnormatic characterized by exact sadness, worthlessness, worthlessness, worthlessness, and a reaction characterized uncertainty and irration. Review of the resident transferround returned to the fact the resident transferround returned to the fact the cognitive impairment, inattention and disorgresident required limit was without swallowing record documented a current weight of 139	a census of 38 residents, eview. Based on and record review, the le nutritional services for 2 esidents reviewed for weight not loss. ysician order sheet, dated noses of dementia (-isorder characterized by ision) with unspecified mental disorder coss impairment in reality disease, esophageal reflux contents to the esophagus), I emotional state ggerated feelings of ess, emptiness and inxiety (mental or emotional dispaperhension, onal fear). ont's medical record, revealed ed to acute care on 8-21-15, icility on 9-8-15. (minimum data set), dated e resident with severe with fluctuating times of	F	325			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	17E531	B. WING _			10/02/2015	
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(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	HOULD BE	(X5) COMPLETION DATE	
		F3	25			
antianxiety medication. The CAA (care area for nutrition, advised regular diet and could regular diet and could. The care plan, dated resident needed associated associated times feed in the electronic medic documented the following on 9-16-15, a weigh On 9-21-15, a weigh On 9-28-15, a weigh On 9-30-15, direct caresident and reported observation, on 9-28 resident with closed dining room. A cup of table in front of the resident a plate with contained biscuits with and a bowl of dry fru resident continued to closed. At 8:42 am, (9 minutes at down beside the resident to eat. The recentimeters) of fluid resident continued to continued to continue to eat. The recentimeters) of fluid resident continued to continue to eat. The recentimeters) of fluid resident continued to continue to eat. The recentimeters) of fluid resident to eat. The recentimeters) of fluid resident continued to eat. The recentimeters) of fluid resident continued to eat. The recentimeters) of fluid resident continued to continue the resident to eat. The recentimeters) of fluid resident continued to continue the resident to eat. The recentimeters) of fluid resident continued to continue the resident to eat. The recentimeters) of fluid resident continued to continue the resident to eat.	assessment), dated 8-21-15, staff the resident was on a d feed him/herself. I 9-10-15, instructed staff the istance at mealtimes and him/herself. Cal record revealed the facility owing weights: It of 126.8 pounds. It of 125.4 pounds. It of 129.6 pounds. It of 129.6 pounds. It of 129.6 pounds. It of staff V weighed the d the weight of 125.6 pounds. In the with pink lemonade sat on the esident. It is later) staff served the a plate guard, which ith gravy and scrambled eggs it loops on the side. The posit quietly with his/her eyes The sident and assisted the resident drank 540 cc (cubic with episodes of coughing					
	SUMMARY S' (EACH DEFICIENCE REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR AND	COUNTY HOSPITAL LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 antidepressant medication and 1 day of antianxiety medication use. The CAA (care area assessment), dated 8-21-15, for nutrition, advised staff the resident was on a regular diet and could feed him/herself. The care plan, dated 9-10-15, instructed staff the resident needed assistance at mealtimes and could at times feed him/herself. The electronic medical record revealed the facility documented the following weights: On 9-16-15, a weight of 126.8 pounds. On 9-21-15, a weight of 125.4 pounds. On 9-28-15, a weight of 129.6 pounds. On 9-30-15, direct care staff V weighed the resident and reported the weight of 125.6 pounds. Observation, on 9-29-15 at 7:42 am, revealed the resident with closed eyes in a wheelchair, in the dining room. A cup with pink lemonade sat on the table in front of the resident. At 8:33 am, (51 minutes later) staff served the resident a plate with a plate guard, which contained biscuits with gravy and scrambled eggs and a bowl of dry fruit loops on the side. The resident continued to sit quietly with his/her eyes	CONTRECTION TRE531 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 antidepressant medication and 1 day of antianxiety medication use. The CAA (care area assessment), dated 8-21-15, for nutrition, advised staff the resident was on a regular diet and could feed him/herself. The care plan, dated 9-10-15, instructed staff the resident needed assistance at mealtimes and could at times feed him/herself. 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The resident made attempts to hold a glass of	CONTRECTION IDENTIFICATION NUMBER: 17E531 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION) Continued From page 34 antidepressant medication and 1 day of antianxiety medication use. The CAA (care area assessment), dated 8-21-15, for nutrition, advised staff the resident was on a regular diet and could feed him/herself. The care plan, dated 9-10-15, instructed staff the resident needed assistance at mealtimes and could at times feed him/herself. The electronic medical record revealed the facility documented the following weights: On 9-16-15, a weight of 126.8 pounds. On 9-28-15, a weight of 126.8 pounds. On 9-29-15, direct care staff V weighed the resident and reported the weight of 125.6 pounds. Observation, on 9-29-15 at 7-42 am, revealed the esident with closed eyes in a wheelchair, in the dining room. A cup with pink lemonade sat on the table in front of the resident. A 8-33 am, (61 minutes later) staff served the resident continued to sit quietly with his/her eyes closed. At 8-42 am, (9 minutes later) direct care staff B, sat down beside the resident and a few bites of fruit loops. The resident made attempts to hold a glass of	The CAA (care area assessment), dated 8-21-15, for nutrition, advised staff the resident needed assistance at mealtimes and could at times feed him/herself. The electronic medical record revealed the resident with closed eyes in a wheelchair, in the dining room. A cup with pink lemonade sat on the table in front of the resident to eat. The resident to eat. The resident to eat. The resident to eat. The resident to esident to eat. The resident to esident to esident to eat. The resident tame staff by and to exploring after swallowing, and a few bites of fruit loops. A BULDING B WINNE B TREET ADDRESS, CITY, STATE, ZIP CODE 807 COURT PL LAKIN, KS 67860 B WINN, KS 67860 D D PREFICIENCY, TAG B STREET ADDRESS, CITY, STATE, ZIP CODE 807 COURT PL LAKIN, KS 67860 D D PREFICIENCY F 325 The CAA (Care area desident on the septiment of the APPROPRIATE F 325 The CAA (care area assessment), dated 8-21-15, for nutrition, advised staff the resident was on a regular diet and could feed him/herself. The care plan, dated 9-10-15, instructed staff the resident meeded assistance at mealtimes and could at times feed him/herself. The electronic medical record revealed the facility documented the following weights: On 9-16-15, a weight of 126.8 pounds. On 9-28-15, a weight of 126.8 pounds. On 9-30-15, direct care staff V weighed the resident and reported the weight of 125.6 pounds. 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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E531	B. WING _			10/02/2015	
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F 325	Continued From pag		F 3	325			
	mouth, at which times the resident. Interview, on 9-29-19 staff B, revealed the speech evaluation for meals, but was not at the resident did not resupplement. Observation, on 9-29 the resident seated a (without a plate guar stroganoff with nood of bread. At this times took the resident aw bathroom. The resident to the district on the table without. At 12:54 pm, (25 min the resident to the district of the resident, the resident to eat. The resident to eat. The resident to	e staff B obtained a straw for 5 at 9:59 am, with direct care resident was to have a procuping during his/her aware of any weight loss, and receive a nutritional 9-15 at 12:29 pm, revealed at the dining table with a plate and which contained beef les, green beans and a slice et, direct care staff T and U ay from the table to use the dent's plate of food remained cover. Inutes later) staff T returned ining room table. The same, and staff U began to assist After further questioning and t's uncovered cold food, when for another warm plate					
	Interview, on 9-29-19 staff S, revealed the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
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F 325	liquids. Staff S stated faxed to the physiciar thicken the resident's diet until the physiciar recommendations. On 9-29-15 at 6:30 president pureed foods thickened liquids, but consume them. The facility policy for advised staff to obtain advised the certified of director of nursing to	cooperative, but had d food and nectar thickened the recommendations were n earlier, but staff could not liquids or provide a pureed n responded to the m, the staff served the s in cups and nectar	F 32	5			
	assistance and dietar resident at risk for we - Review of resident record, revealed the r facility on 6-12-15. The history and physi diagnoses included d (condition characteriz the thyroid gland), may be said to be said	•					
	The admission MDS	(minimum data set), dated					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		17E531	B. WING _			10/02/2015	
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F 325	cognitive impairment eating, no impairment swallowing or dental inches, and a weight no/unknown weight in the CAA (care area and fluid maintenance the resident with a difluids well at meals a urinary tract infection. The CAA for nutrition. The CAA for nutrition. The care plan, dated resident's risk for we and the need to weight provide ensure with resident when it is must have a considered to the physician of the resident's choice. Review of the weight the following: On 6-23-15, weight of On 8-17-15, weight of On 9-28-15, weight of On 9-30-15, weight of On 9-30-	ne resident with severe required supervision for at of extremities, no problems, a height of 65 of 149 pounds, with oss. assessment) for dehydration re, dated 6-24-15, assessed agnoses of dementia, drinks and snacks, had a history of res. did not trigger. 6-24-15, advised staff of the right loss due to dementia reals and to remind the realtime. sician, dated 8-5-15, advised resident's 10 pound weight rece to be given with meals. res for the resident, revealed of 151 pounds. residents for a supplement rece to be given with meals. residents for a supplement rece to be given with meals. residents for a supplement rece to be given with meals. residents for a supplement rece to be given with meals. residents for a supplement rece to be given with meals. residents for a supplement rece to be given with meals. residents for a supplement rece to be given with meals.	F3	25			
		e dining room table, drinking					

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		17E531	B. WING _			10/02/2015
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 325	staff B, revealed the drank the ensure su meal. Observation, on 9-2 resident was served scrambled eggs. The each. Observation, on 9-2 the resident was served potato with chili and and 8 ounces of ensilverware was wrapplate of food. The rewatermelon from 2 sof food, with his/her remained wrapped i staff member sat ac another resident but problem and assiste his/her silverware or would like something.	5 at 7:30 am, with direct care resident most generally pplement provided at each 9-15 at 8:33 am, revealed the biscuits with gravy and e resident consumed 70 % of 9-15 at 12:29 pm, revealed ated at the dining table. The the a plate with a baked cheese, broccoli with cheese, sure. The resident's pped in a napkin beside the esident ate olives and small bowls beside the plate hands, while the silverware in the napkin. A direct care ross this table assisting a none of the staff noted the ed the resident to unwrap asked the resident if he/she g else to eat.	F3	25		
	consumed, and the in the napkin. No sta unwrap his/her silve he/she would like so Interview, on 9-29-1 staff U, revealed diresidents to eat, but	5 at 1:30 pm, with direct care ect care staff assisted the did get called away to toilet call lights, so meals were				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E531	B. WING			10/	02/2015
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F 325	The facility failed to p assistance and week risk for weight loss.	weights, revised 8-2015, n weekly weights. rovide consistent dining ly weights for this resident at		325			
F 329 SS=D	Each resident's drug unnecessary drugs. drug when used in ex duplicate therapy); or without adequate mo indications for its use adverse consequences should be reduced or combinations of the resident, the facility may who have not used at given these drugs untherapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral interventic contraindicated, in an drugs.	regimen must be free from An unnecessary drug is any accessive dose (including a for excessive duration; or anitoring; or without adequate and a for excessive duration; or anitoring; or without adequate and any assons above and assessment of a anust ensure that residents antipsychotic drugs are not alless antipsychotic drug and to treat a specific condition and any	F	329			
	This REQUIREMENT by: F329-D	is not met as evidenced					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
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F 329	Continued From pag		F3	329		
	16 residents included observation, interview facility failed to ensure for unnecessary medianitoring for antihy monitoring for PRN (a census of 38 residents with d in the sample. Based on w, and record review, the re 2 of 5 residents reviewed dications received adequate pertensive medications, as needed) medications (#25 ate justification of use (#31).				
	history and physical frontotemporal lobe of mental disorder char and confusion), depr emotional state char feelings of sadness, emptiness), hyperter pressure) and psych	nsion (elevated blood osis (any major mental ed by a gross impairment in				
	(Minimum Data Set) BIMS (Brief Interview 0, indicating severe	nt's Comprehensive MDS dated 10/14/14 revealed a of for Mental Status) score of cognitive impairment. During in period, he/she received an antibiotic daily.				
	(Care Area Assessm the resident had a di	osocial Well-Being CAA ent) dated 10/20/14 revealed agnosis of dementia and dent had short and long term nfusion.				
		nt's Quarterly MDS dated resident had both short and				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E531	B. WING		10/02/2015	
	ROVIDER OR SUPPLIER	cu	STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 329	severely impaired codecision making. Duperiod, he/she received he/she received he/she received he/she resided 10/30/13, revealed madministered as president for hypoland constipation. Review of the physic following medication: 1/22/14- Lorazepam medication: 1/22/14- Lorazepam medication: 1/22/14- Lorazepam medication: 1/22/14- Lorazepam medication: 1/22/14- Metoproloid: antihypertensive medically (Hold if apical periodically (Hold if apical periodically) (Hold if apical periodically). Review of the July 20 Administer administered Loraze but did not document effectiveness. Review of the August administered MOM of BM (bowel movement follow-up for effectiveness).	roblems and the resident had gnitive skills for daily ring the 7-day observation red an antidepressant daily. Int's care plan, initiated nedications were to be scribed. Staff were to monitor tension (low blood pressure) Isian's orders revealed the swith their start dates: Plogel (an antianxiety illigram) topically PRN (as sours. Succinate (an dication) 25 mg by mouth rulse <60 BPM). Itesia (MOM) 400 mg/5 mL 30 mL by mouth PRN every Interest MAR (Medical red) revealed staff pam Plogel 1mg on 7/21/15 to the reason or follow up for the 10 list but staff did not eness. Interest MAR revealed complete the 10 mg/3/15. Staff son given as "list" and did	F 329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		STRUCTION		E SURVEY PLETED
		17E531	B. WING _			10	/02/2015
	ROVIDER OR SUPPLIER	U	,	607 CO	TADDRESS, CITY, STATE, ZIP CODE BURT PL I, KS 67860	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From page	e 42	F 3	529			
	resident's pulse rate	ays in July 2015, 27 of 30					
	the resident sat in the room with other resid resident was calm an	30/15 at 3:00 PM revealed e special care unit activity ents watching TV. The d did not exhibit any nd responded appropriately					
	care staff Q stated he blood pressures in th medications which re resident #25 was not checked pulses for. S Metoprolol clearly sta	en 9/30/15 at 3:17PM, direct elshe checked pulses and e morning before giving quired it. Staff Q stated one of the residents he/she staff Q verified the order for ated the medication should te less than 60 BPM (beats					
	licensed nursing staff order for Metoprolol s	n 9/30/15 at 3:32 PM, K verified the physician's stated to hold medication if art rate of less than 60 BPM.					
	administrative nursing expected a nurse or obtain a pulse prior to if the doctor ordered there to be a reason.	on 9/30/15 at 4:08 PM, g staff C stated he/she certified medication aide to administering a medication it. Staff C also expected staff administered a PRN v-up for effectiveness.					
		s Medication Administration 2009, revealed following the					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		OATE SURVEY OMPLETED	
		17E531	B. WING _			10/02/2015	
	ROVIDER OR SUPPLIER	cu	STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 329		le 43 PRN medication, a follow up sed nursing staff should be	F	329			
	· ·	ffectiveness of the PRN					
	monitoring of the res	ensure follow up for N medications given and sident's pulse as ordered medication as ordered for					
	admitted on 8/26/14, including; depressive emotional state char feelings of sadness, and hopelessness), disorder characterize	* * *					
	6/5/15, revealed the interview for mental intact cognition. The	(minimum data set), dated resident had a BIMS (brief status) score of 15, indicating resident had no signs or n. Mood score of 3, which					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED
		17E531	B. WING _			10/02/2015
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LTC	U		STREET ADDRESS, CITY, STATE, ZIP C 607 COURT PL LAKIN, KS 67860	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATI	(X5) COMPLETION DATE
F 329	revealed the resident depressed, or hopele staying asleep, or sle less. The resident recanti-depressant and has a modern or sident 's mood interevealed minimal dep diagnosis which incluresident had 1 non-nadmission or prior as on antipsychotic, antianticoagulant, and diagnosis which incluresident had 1 non-nadmission or prior as on antipsychotic, antianticoagulant, and diagnosis which incluresident had 1 non-nadmission or prior as on antipsychotic, antianticoagulant, and diagnosis which incluresident was on antipsychotic, antianticoagulant, and diagnosis which inclures antipsychotic, antianticoagulant, and diagnosis on antipsychotic medication, reduction in some of tried, the resident bedirritated. The resident sleep aide, and receival Lexapro for depressional or included and oriented, and coundecisions. The CAA lapsychosocial or mood symptoms for the resident was watch television to he drink and keep the here. Review of the physiciantic staying as a modern or side of the physiciantic depression in the phys	had feelings of being down, ss, and had trouble falling or eping too much on 1 day or seived antipsychotic, hypnotic medications. Med 9/2/15, revealed the erview scored a 1, which bression. The resident had ded depression. The hajor injury fall since sessment. The resident was depressant, hypnotic, furetic. Assessment), dated 9/10/15, otropic drug use area, the sychotic, antidepressant and and documented when a his/her medications were came easily angered and a received the hypnotic as a wed the medication of on, Xanax for anxiety and easis. The resident was alert alld make his/her own acked documentation for the distate or behavioral	F3	329		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
		17E531	B. WING _			10/02/2015
	ROVIDER OR SUPPLIER	·u	•	STREET ADDRESS, CITY, STATE, ZIP COD 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 329	Continued From pag		F 3	329		
	medication) 30 mg (r Depressive disorder.	nlligrams), daily, for				
	On 8/31/15- Risperid (antipsychotic medica mouth), 2 times daily	ation), 0.25 mg, po (by				
	administration record documented on 8/31, resident received Ris licensed nursing staff	(electronic medication) monthly report, (15 at 1800 (6:00 PM), the peridone 0.25 mg, by f W, and also the resident e ODT 0.25 mg at 1800 by				
	stated the Risperidor	PM, direct care staff Q, ne ODT should have been ication cart prior to the dent.				
	staff C, reviewed the documentation, and revealed the resident	M, administrative nursing monthly EMAR verified the documentation was given an additional on 8/31/15 at 6:00 PM.				
	electronic record lack	of the assessments on the sed a hypnotic or sleep esident who received a daily				
	for the elderly form, or resident 's medication Risperdal, 0.25 mg, El Temazepam, 30 mg, documented the medication and the medi	at bedtime. The form				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E531	B. WING		10/02/2015	
	ROVIDER OR SUPPLIER	cu	6	TREET ADDRESS, CITY, STATE, ZIP CODE 07 COURT PL AKIN, KS 67860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 329	medications, the phy with, No, Continue, a why so the records of physician documents is diagnoses. Hower physician is factors benefits statement to the continued use of resident. On 9/30/2015 at 8:18 K, stated the Restori for insomnia. On 9/30/2015 at 2:5 K, stated the resident and that the resident pattern. Licensed nut facility failed to compute resident. On 9/30/2015 at 3:25 K, stated the resident pattern. Licensed nut facility failed to compute resident. On 9/30/2015 at 3:25 nursing staff C, stated generally given for distated the resident disleping. Administratically given for distated the resident disleping. Administratically given for this resident disleping. Administratically given for this resident disleping. The facility failed to excessive medication facility failed to asset	continue to receive the sician should mark the box and then indicate the reasons could be updated. The ed to continue for the resident ever, the form lacked the related to a risk versus of explain the reasoning for these medications for the ed to a risk versus of explain the reasoning for these medications for the ed to a risk versus of explain the reasoning for these medications for the explain the reasoning staff of the explain the reasoning staff of the explain the problem with sleep, did not have a regular sleep rising staff K verified the explain	F 329			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		17E531	B. WING			10/	02/2015
	ROVIDER OR SUPPLIER	U	•	60	TREET ADDRESS, CITY, STATE, ZIP CODE D7 COURT PL AKIN, KS 67860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329 F 333 SS=D	Continued From page without risk versus be physician. 483.25(m)(2) RESIDE SIGNIFICANT MED E	enefit reasons from the ENTS FREE OF		329 333			
	The facility must ensuany significant medica	ure that residents are free of ation errors.					
	by: The facility census to included in the sampl interview, and record ensure 1 of 5 residen	otaled 38 residents, with 16 e. Based on observation, review, the facility failed to ts reviewed for unnecessary e of significant medication					
	note dated 4/11/14, re unspecified psychosis characterized by a greatesting) and insomnia stay asleep). Review physician order sheet additional diagnoses emotional state charafeelings of sadness, wemptiness), hypothymot produce enough to depressive disorder (characterized by exagusadness, worthlessness), demedisorder characterizeed	s (any major mental disorder oss impairment in reality (inability to fall asleep and of an electronically signed at dated 8/28/15 revealed of depression (abnormal acterized by exaggerated worthlessness and oidism (when the body does hyroid hormone), abnormal emotional state ggerated feelings of ess, emptiness and ontia (progressive mental					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE	SURVEY
		17E531	B. WING_			10/	02/2015
	ROVIDER OR SUPPLIER	U		607 C	EET ADDRESS, CITY, STATE, ZIP CODE COURT PL IN, KS 67860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	irrational fear). The quarterly MDS (r 1/13/15, revealed her interview for mental scognitive impairment of delirium or behavior independent with bedwalking in the room a received daily antided days of antibiotics duperiod. The annual MDS dathad no change in cog (activities of daily living assessment. The resum and antidepressant in 7-day observation per Review of the Psychological procession of the Psychologi	notional reaction rehension, uncertainty and minimum data set) dated she had a BIMS (brief stats) of 0, indicating severe He/she exhibited no signs ors. The resident was I mobility, transfers, and and corridor. The resident pressant medication and 3 ring the 7-day observation are doing to be a finition, behaviors, or ADL org) ability from the previous ident received antipsychotic nedications daily during the	F	333	DETIGENOTY		
	unit). His/her behavior was more compliant and showering. The resident had a his behaviors, depression. Review of the resident received the resident resident resident received the resident received the resident received the resident resident resident received the resident resident received the rece	at in the SCU (special care are had improved and he/she with cares such as shaving resident's medications viewed by the director of narmacist, and physician. story of dementia with n, anxiety and psychosis. If Lexapro and Trazodone for at's care plan initiated resident had resistive					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		17E531	B. WING _			10/02/2015
	ROVIDER OR SUPPLIER	cu		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 333	had a goal for stabili: frequency of resistive days. Interventions of medications as prese antidepressant meditrazadone. Monitor as symptoms to the phyextenders. Review of the 7/23/1 care plan, revealed to Exelon for demonstrate plan, revealed to Exelon for demonstrate place patch in same exact spot should be to Levothyroxine for Namenda XR for Trazadone for divorsening depression. Review of an electron included in a physicial daily for demonstrate dates: 2/21/15- Exelon patch topical daily for demonstrate dates: 2/21/15- Trazodone 5 depression.	care and or treatment) and zation or decline in the e behaviors within the next 90 directed staff to administer cribed, including cations Lexapro and and report any drug related visician or physician 5 Medication management the following medications: entia/memory enhancement. and memory status. Do not spot for 14 days and the protated. For hypothyroidism, ar memory enhancement. The epression. Monitor for in. Inically signed medication list, and 's visit note dated to following medications with the state of the ential with behavioral the sodium 75 mcg by the daily for unspecified to mg PO daily for depressive of mg PO at bedtime for the state of	F3	33		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		17E531	B. WING _			10/02/2015
	ROVIDER OR SUPPLIER	cu		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 333	the physician saw th and physical. The re to the use of Exelon were not removing the new patch. The physical patch at a lower dose behaviors had since. Review of a Nursing 6/6/15, revealed a dipatches on the reside dated 6/6/15. Staff resident 's Lexapro, trazodone from 8/1/1 not received it. The resident 's Lexapro, trazodone from 8/1/1 not received it. The resident 's Lexapro, trazodone from 8/1/1 not received it. The resident 's Lexapro, trazodone from 8/1/1 not received it. The resident 's Lexapro, trazodone from 8/1/1 not received it. The resident 's Lexapro, trazodone from 8/1/1 not received it. The resident 's Lexapro, trazodone from 8/1/1 not received it. The resident 's Lexapro, trazodone from 8/1/1 not received it. The resident 's Lexapro, trazodone from 8/1/1 not received it. The resident received it to hir headache, diarrhea, physician replied for medications were not reviews dated: 6/11/15, revealed the incident report regard with two Exelon patch care staff. 7/11/15, revealed a review of the pharm reviews dated: 6/11/15, revealed a review of the pharm reviews dated: 6/11/15, revealed a review of the pharm reviews dated: 6/11/15, revealed a review of the pharm reviews dated: 6/11/15, revealed a review of the pharm reviews dated: 6/11/15, revealed a review of the pharm reviews dated: 6/11/15, revealed a review of the pharm reviews dated: 6/11/15, revealed a review of the pharm reviews dated: 6/11/15, revealed a review of the pharm reviews dated: 6/11/15, revealed a review of the pharm reviews dated: 6/11/15, revealed a review of the pharm reviews dated: 6/11/15, revealed a review of the pharm reviews dated: 6/11/15, revealed a review of the pharm review of the phar	n note dated 5/8/15, revealed to resident for a yearly history sident had a seizure related patches. Staff noted they note old patch when placing a sician had discontinued the ter, the resident began to mappropriate behaviors mysician restarted the Exelon to an and the resident 's improved significantly. If Physician report dated rect care staff found 2 Exelon tent's back that were both temoved both patches at If Physician report dated facility did not have the Namenda, levothyroxine and 5-8/4/15, so the resident had	F3	333		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E531	B. WING		10/02/2015
	ROVIDER OR SUPPLIER	CU		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	1 1010212010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 333	8/10/15, revealed not did not identify the fathe resident 's Lexa and trazadone. Observation on 9/30 direct care staff Q gather and he/she took them. An attempt on 9/29/resident did not wanton on 9/30/15 at 11:45 explained the facility reordering; He/she standing the medication card had CMA (certified medication card had CMA (certified medication the got really low on the reported to the charge pharmacy. Staff Q so out of medications for out-of-town pharmacy and the resident on time. Staff Q reput days when the resident the resident 's medication at 4:45 PM, revealed not receive medication in pharmacy only delivered.	on of the drug for 12 days. It concerns. The pharmacist acility's failure to administer pro, Namenda, levothyroxine, It at 8:09 AM, revealed ave the resident medications in without any issues. It at 3:07 PM, revealed the average to be interviewed. AM, direct care staff Q system for medications it atted when a resident's only about 5 days left, the cation aide) faxed the em the resident needed a day and the resident medication, the CMA genurse, who then called the stated the problem of running or residents was due to be seen the stated it had ents went without the re-orders did not come in corted he/she knew of several ent went without medications not available. The definition of the point, the resident did ons for days. Staff R reported cations came from a another town and that	F 33	3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		17E531	B. WING			10/	02/2015
	ROVIDER OR SUPPLIER	U	•	6	STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	times, a maintenance medications if the res Staff R reported usual medications and any another town's pharbefore the resident at medication. Staff R rereceive the medication the emergency medic pharmacy in town, or from the hospital. State done that for resident his/her medications a occasions. Interview on 9/30/15 administrative nurse and the facility needeensure residents recordered. Nurse C repincidents regarding the administered as well except a medication, review when administering in follow the six rights of (time, person, dose, redocumentation). The facility failed to e accurately administer medications, resulting medications, resulting medications, resulting	e staff member picked up ident really needed them. Illy the CMA re-ordered medication that came from macy, staff ordered 7 days ctually ran out of the eported if the facility did not ns in time, staff looked in eation kit first, then called the borrowed the medication ff R confirmed no one had #28 and he/she did not get s ordered on a few at 5:15 PM, with C revealed the resident without his/her medications d to work on their process to eived their medications as orted he/she knew of the ne medications that were not as the incident with the dual policy for Medication wed on 8/2009, revealed nedications, staff were to f medication, route, and insure staff safely and	F	3333			
F 371 SS=F	errors. 483.35(i) FOOD PRC STORE/PREPARE/S		F:	371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		17E531	B. WING _			10/02/2015
	ROVIDER OR SUPPLIER	cu		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371	considered satisfactor authorities; and	n sources approved or ory by Federal, State or local istribute and serve food	F 3	71		
	by: The facility census to facility served food to kitchen into two separation, intervier facility failed to ensure sanitary manner and	T is not met as evidenced totaled 38 residents. The coall residents from one main arate dining rooms. Based on w, and record review, the re staff served foods in a I to ensure staff properly with open dates and contents.				
	- During an observathe refrigerator in the contained: - 3 unlabeled/unce glasses with a contacolored fruit in a plast dessert - a plastic bottle I 8/9/15 with no expiration a zip lock bag with no label or date the freezer contained.	rith sliced summer sausage				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E531	B. WING			10/	02/2015
	ROVIDER OR SUPPLIER	EU		6	TREET ADDRESS, CITY, STATE, ZIP CODE 07 COURT PL AKIN, KS 67860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	as flour without an op- freezer did not contain monitoring the freezer. On 9/28/15 at 8:50 Addining room revealed. Dietary staff A served residents. Staff A wor to place scrambled efor bacon and sausas. However, he/she also muffins with the same the plate, utensils, pare did not be plate, utensils, pare did not be plate of appresidents of the SCU contaminated gloved placed it on the plate staff O, who assisted staff O pushed aroun while wearing single- used the same glove pour spout of the dry pouring out the dry contained directly on single- gloved hand before grandividual bowls. On 9/28/15 at 10:45 and direct care staff B put gloves, picked up a part of the contained the cont	ag with white powder labeled been date on the bag. The in a thermometer for a temperatures. M, observation of the SCU a steam table cart entered. I breakfast plates to the re gloves and used utensils ggs on the plate, and tongs ge for the first few plates. O picked up the toast and re gloves he/she had touched ans, and other surfaces. For oximately half of the growing this time, dietary in the SCU dining room, die a cart with dry cereals use gloves. Staff O then die hands to place over the cereal containers, when real. The dry cereal taff O's contaminated to ing on into the residents. AM, in the SCU living room, and a pair of single-use collate of cookies, touched the used the same contaminated up each cookie and handed.	F	371			
	On 9/30/15 at 8:45, a stated this was not ac	administrative nurse N, cceptable.					

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONST		(X3) DATE	E SURVEY PLETED
		17E531	B. WING _			10.	/02/2015
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LTC	U		607 COU	ADDRESS, CITY, STATE, ZIP CODE RT PL KS 67860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From page	e 55	F3	71			
	sanitary manner by thuse single-use gloves	nsure staff served foods in a ne failure to appropriately s and failed to ensure staff en dates and contents.					
F 425 SS=D	483.60(a),(b) PHARM ACCURATE PROCE		F 4	25			
	drugs and biologicals them under an agreet §483.75(h) of this par unlicensed personnel law permits, but only supervision of a licen. A facility must provide	t. The facility may permit to administer drugs if State under the general sed nurse. e pharmaceutical services that assure the accurate					
		rugs and biologicals) to meet					
	a licensed pharmacis	loy or obtain the services of t who provides consultation provision of pharmacy					
	by: The facility census to included in the sampl interview, and record maintain an effective provision of medicatio to meet the needs of	otaled 38 residents, with 16 e. Based on observation, review, the facility failed to procedure to ensure the ons/pharmaceutical services, 3 of 5 sampled residents esary medications. (#28, #31,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E531	B. WING _		,	10/02/2015	
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LTC	eu		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 425	note dated 4/11/14, runspecified psychosi characterized by a gratesting). Review of an physician order shee additional diagnoses emotional state charafeelings of sadness, emptiness), depressi emotional state charafeelings of sadness, and hopelessness), of mental disorder characterized by appirrational fear). Review of the resider (minimum data set) of he/she had a BIMS (I stats) of 0, indicating impairment. He/she or behaviors. The resided mobility, transfer and corridor. The resided mobility, transfer and corridor, the resided mobility of the resided mobility, transfer and corridor, the resided mobility of the resided mobility.	#28's physician progress evealed a diagnosis of s (any major mental disorder ross impairment in reality in electronically signed it dated 8/28/15, revealed of depression (abnormal acterized by exaggerated worthlessness and ve disorder (abnormal acterized by exaggerated worthlessness, emptiness dementia (progressive acterized by failing memory, vioral disturbance, and notional reaction rehension, uncertainty and to severe cognitive exhibited no signs of delirium sident was independent with s, and walking in the room ident received daily cation and 3 days of 7-day observation period. Int's annual MDS dated with sex annual MDS dated she had no change in or ADL (activities of daily a previous assessment. The	F 4	25			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				OATE SURVEY COMPLETED		
		17E531	B. WING _			10/02/2015
	ROVIDER OR SUPPLIER	CU		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 425	Review of the Psych area assessment) da resident received Ge medication) for psyc adjusted to placeme unit). His/her behavious more compliant and showering. The would be routinely renursing, consulting particles and the behaviors, depression resident had a goal for stability frequency of resisting had a goal for stability frequency of resisting had a second resisting had a second resisting had a goal for stability frequency of resisting had a second resisting had a second resisting had a goal for stability frequency of resisting had a second	otropic Drug Use CAA (care ated 7/16/15, revealed the eodon (an antipsychotic hosis. The resident had nt in the SCU (special care ors had improved and he/she with cares such as shaving resident 's medications eviewed by the director of obarmacist, and physician. history of dementia with on, anxiety and psychosis. Int's care plan dated the resident had resistive care and or treatment) and zation or decline in the te behaviors within the next 90 directed staff to administer	F 4	,		
	orders dated 8/28/18 Geodon 20 milligram ordered on 6/24/15, Review of a 6/23/15 revealed staff noted his/her Geodon since period of 12 days. Since Geodon due to medicart. Staff found the drawer in medication evening. The physic	onically signed physician 5, revealed an order for ins (mg) twice daily initially for unspecified psychosis. nursing/physician report, the resident did not receive e 6/9/15, until 6/22/15, a time taff did not administer the faction not available in the medication in the overstock in room on 6/21/15 in the fain then ordered staff to in to 20 mg, by mouth, every iter the resident for				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	1, ,	ATE SURVEY OMPLETED
		17E531	B. WING			10/02/2015
	ROVIDER OR SUPPLIER	CU		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	. '	10/02/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 425	review, dated 7/11/1 reduction for the resonot indicate the phatomission of the drug. Observation on 9/30 direct care staff Q at the resident who too. An attempt on 9/29/resident did not war. On 9/30/15 at 11:45 explained the facility reordering; He/she's medication card had CMA (certified medipharmacy alerting the refill. Then if the CM not come in from the got really low on the reported to the charpharmacy. Staff Q sout of medications frout-of-town pharmach appened the resident #28 went with medications because Interview, with license 4:45 PM, revealed a not receive medication to medication to medications the resident secure with the resident secure medication to medication the resident secure medication the resident s	nacist's drug regimen 5, revealed a recent dose ident's Geodon, but it did rmacist identified the g for 12 days. 0/15 at 8:09 AM, revealed dministered medications to ok them without any issues.	F 42	25		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E531	B. WING _			10/02/2015
	ROVIDER OR SUPPLIER	cu		STREET ADDRESS, CITY, STATE, ZIP COD 607 COURT PL LAKIN, KS 67860	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 425	up medications if the Staff R reported usu medications and any a pharmacy in anoth 7 days before the remedication. Staff R receive the medication the emergency med pharmacy in town, of from the hospital. St done that for resider his/her medications occasions. Interview on 9/30/15 administrative nurse should not have gon and the facility need ensure residents recordered. Review of the facility Medication Usage a 8/2015, revealed nuresponsible for followand intervention pro appropriate administrative medication.	ered on Mondays, days. Staff R further nance staff member picked e resident really needed them. ally the CMA re-ordered medication that came from neer town, staff were to reorder sident actually ran out of the reported if the facility did not not sin time, staff looked in faction kit first, then called the reported the medication aff R confirmed no one had not #28 and he/she did not get as ordered on a few The action of the revealed resident #28 are without his/her medications are to work on their process to revealed their medications as a policy for Psychotropic and Monitoring, revised resing staff would be wing medication monitoring cedures to ensure the tration procedure of each	F 4	25		
	history and physical frontotemporal lobe mental disorder char	t #25 's physician signed revealed diagnoses including dementia (a progressive racterized by failing memory ressive disorder (an abnormal				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E531	B. WING		10/02/2015	
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LT	си	STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION	
F 425	emotional state charfeelings of sadness, emptiness), hyperte pressure), and psychia disorder characteriz reality testing) with the Review of the reside (Minimum Data Set) BIMS (Brief Interview O, indicating severe the 7-day observation antidepressant and Review of the Psychia (Care Area Assessmanthe resident had a depression. The resident had a depression. The resident had a depression. The resident had a depression of the physical medications with the 7/21/15- Levaq (milligrams) PO (by days for an upper resident of the physical for 1 week the Review of the July 2 Administration Recopresent on med (meand the resident refiphysician ordered for days of antibiotics for the present of the physician ordered for days of antibiotics for the present of the physician ordered for days of antibiotics for the present of the physician ordered for days of antibiotics for the present on med (meand the resident refiphysician ordered for days of antibiotics for the present on med (meand the resident refiphysician ordered for days of antibiotics for the present of the physician ordered for days of antibiotics for the present on med (meand the resident refiphysician ordered for days of antibiotics for the present on the present of the physician ordered for days of antibiotics for the present of the present of the physician ordered for days of antibiotics for the present of the prese	racterized by exaggerated worthlessness and nsion (elevated blood hosis (any major mental ed by a gross impairment in behaviors. ent's Comprehensive MDS addted 10/14/14 revealed a w for Mental Status) score of cognitive impairment. During on he/she received an an antibiotic daily. nosocial Well-Being CAA ment) dated 10/20/14 revealed iagnosis of dementia and ident had short and long-term onfusion. ent's care plan, initiated medications were to be scribed. cian's orders revealed e following start dates: uin (an antibiotic) 500 mg mouth) administer daily for 5 espiratory infection. epine (Zyprexa) 2.5 mg PO in 5 mg daily.	F 425			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		17E531	B. WING		10/02/2015	
	ROVIDER OR SUPPLIER	cu	STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		, 10.02.2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
F 425	Zyprexa "med not of 9/30/15. Review of the Progrewritten by licensed in had not arrived from town. Review of the Progrewritten by licensed in contacted the pharm the Zyprexa and the delivered this afternotated this afternotated this afternotated this afternotation on 9/10 the resident sat in the room with other resident acted calming negative behaviors. During an interview of licensed in the medication of the resident was only medication 3 out of 50. During an interview of administrative nursing staff in the resident was only medication 3 out of 50.	mber 2015 MAR revealed: on cart " on 9/29/15 and ess Note dated 9/29/15 urse S stated the Zyprexa the pharmacy from another ess Note dated 9/30/15 urse S stated the staff acy regarding the delivery of pharmacy stated it should be con. 30/15 at 3:00 PM revealed the special care unit activity dents watching TV. The y and did not exhibit any on 9/30/15 at 5:42 PM, of R stated if an antibiotic was sing available or the resident con, he/she would contact the of the situation to see if staff of finish the missed doses. on #25 should have as as ordered, and confirmed y given the ordered antibiotic of days ordered. on 9/30/15 at 5:52 PM, g staff C stated the nurse	F 4:	25		
	should have made a to the antibiotic entry	separate order to add 2 days for the doses that were ne resident to complete the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		17E531	B. WING			10/	02/2015
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(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425	antibiotic as ordered. not done according to Report. Review of the facility policy last updated 3/notify the physician's nurse if any medication. The facility failed to emedications as ordered as	Staff C confirmed this was a the July 2015 MAR Monthly 's Medication Administration 2009, revealed staff were to hall be notified by the charge ons were held. Insure resident #25 received ed. It have signed or electronic ers. The electronic chart I, admitted on 8/26/14, with es including: chronic inflammatory disease elerized by variable and reversible airflow (swelling resulting from an ion of fluid in the body live heart failure (a condition and the body becomes	F	425			
	with exertion.	ess and shortness of breath an orders included the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	. , ,	ATE SURVEY DMPLETED
		17E531	B. WING _			10/02/2015
	ROVIDER OR SUPPLIER	cu	•	STREET ADDRESS, CITY, STATE, ZIP CO 607 COURT PL LAKIN, KS 67860	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 425	day for chronic obst 12/31/14- Burner (by mouth) 2 times or 12/31/14- Ipratr inhalation 4 times a asthma Review of the EMAF administration record to September 2015: Staff document Ipratripium bromide times. The medication 7/8/15, 7/21/15, 8/5/9/6/15. Staff did not add inhalation solution 8 omitted on 7/8/15, 7/8/9/15, 9/1/15, 9/6/15. Staff did not add inhalation solution 8 omitted on 7/8/15, 7/8/9/15, 9/1/15, 9/6/15. On 9/30/15 at 3:29 Istaff C verified there in the electronic recordirector of nurses us omissions, but state checking to ensure a medications as order Review of a Medical	is with start dates: all sulfate nebulizer 4 times a ructive asthma etanide 2 mg (milligrams) polarily for edema ipium bromide (Atrovent) day for chronic obstructive R (electronic medication dd) monthly reports from July ed the inhalation medication was not administered 9 on was omitted on 7/ 4/15, 1/15, 8/9/15, 9/1/15 and, minister Albuterol sulfate times. The medication was 1/21/15, 7/21/15, 8/5/15, 5, and 9/26/15. minister Bumetanide on of the control of the cont	F 4	125		
	notified anytime medication administ safe and orderly ma	ed the physician should be dications were held and ration would be done in a nner. ensure resident #31 received				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		17E531	B. WING		10/02/	/2015	
	ROVIDER OR SUPPLIER	eu		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 425	Continued From page 64		F 42	25			
F 428 SS=E	-	ations for his/her well-being. GIMEN REVIEW, REPORT NN	F 42	28			
	• •	each resident must be te a month by a licensed					
	the attending physicia	report any irregularities to an, and the director of eports must be acted upon.					
	by: The facility reported with 16 included in th were selected for rev medications. Based or record review, the fac pharmacist identified	on observation, interview and cility failed to ensure the and reported any regimen reviews for 4 of 5					
	Findings included:						
	history and physical r frontotemporal lobe of mental disorder chara and confusion), depre emotional state chara feelings of sadness, r emptiness), hyperten	· · · · · · · · · · · · · · · · · · ·					

	(X3) DATE SURVEY COMPLETED	
17E531 B. WING 10/02/	2/2015	
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 428 Continued From page 65 disorder characterized by a gross impairment in reality testing) with behaviors. Review of the resident's Comprehensive MDS (Minimum Data Set) dated 10/14/14 revealed a BIMS (Brief Interview for Mental Status) score of 0, indicating severe cognitive impairment. During the 7-day observation period, he/she received an antidepressant and antibiotic daily. Review of the Psychosocial Well-Being CAA (Care Area Assessment) dated 10/20/14 revealed the resident had a diagnosis of dementia and depression. The resident had short and long term memory loss with confusion. Review of the resident's Quarterly MDS dated 6/25/15 revealed the resident had both short and long-term memory problems and the resident had severely impaired cognitive skills for daily decision making. During the 7-day observation period, he/she received an antidepressant daily. Review of the resident's care plan, initiated 10/30/13, revealed medications were to be administered as prescribed. Review of the physician's orders revealed the following order with start date: 77.21/15. Levaquin (an antibiotic) 500 mg (milligrams) PO (by mouth) administer daily for 5 days for an upper respiratory infection. Review of the July 2015 MAR (Medical Administration Record) revealed: Levaquin "not present on med (medication) cart "on 7/22/15 and the resident refused on 7/26/15. The physician ordered for the resident to receive 5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E531	B. WING _			10/	02/2015
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LTC	U		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 428	only received it for 3 of Review of resident 's the consultant pharm monthly medication reto identify resident #2 series of antibiotics a An observation on 9/3 the resident sat in the room with other resident resident acted calmly negative behaviors. During an interview of licensed nursing staff only received the ordeout of 5 days. During an interview of administrative nursing should have made a stag days that the antibiotithe resident to complest the July 2015 EMAR reported the pharmacon regimens monthly of got a copy of the pharecommendations. Afthe recommendations them to the physician	medical records revealed acist staff X completed a eview on 8/10/15 and failed 5 did not complete the sordered. 80/15 at 3:00 PM revealed especial care unit activity ents watching TV. The and did not exhibit any 10 9/30/15 at 5:42 PM, 11 R confirmed resident #25 ered antibiotic medication 3 11 9/30/15 at 3:30 PM, as staff C stated the nurse separate order to add the 2 c was missed in order for ete the antibiotic as ordered. It was not done according to Monthly Report. Staff C stated the nurse stall the residents, then he/she macist 's ter he/she looked through and then once he/she got hysician, he/she faxed them	F	128			
	-	pharmacy consultant staff 10/1/15 at 2:16 pm was X was not available.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	1, ,	E SURVEY PLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	Continued From pag	ge 67	F 42	8		
	pharmacist identified administration when antibiotics as ordered - Review of residen note dated 4/11/14, unspecified psychos characterized by a getesting) and insommistay asleep). Review physician order she additional diagnoses emotional state characterings of sadness, emptiness), hypothy not produce enough depressive disorder characterized by exadness, worthless hopelessness), dem disorder characteriz confusion) with behavior anxiety (mental or echaracterized by aprirrational fear). The quarterly MDS of 1/13/15, revealed he interview for mental	t #28 's physician progress revealed diagnoses of sis (any major mental disorder gross impairment in reality a (inability to fall asleep and of an electronically signed et dated 8/28/15 revealed so of depression (abnormal racterized by exaggerated worthlessness and roidism (when the body does thyroid hormone), (abnormal emotional state aggerated feelings of gress, emptiness and entia (progressive mental ed by failing memory, avioral disturbance, and motional reaction prehension, uncertainty and fininimum data set) dated exshe had a BIMS (brief stats) of 0, indicating severe				
	of delirium or behav daily antidepressant antibiotics during the The annual MDS da	t. He/she exhibited no signs fors. The resident received medication and 3 days of a 7-day observation period.				
		gnition or behaviors from the nt. The resident received				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E531	B. WING		10/02/2015		
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LTG	си	STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
F 428	antipsychotic and ar daily during the 7-daily director of the Psychaedication would be director of nursing, or physician. The reside with behaviors, depropsychosis. The reside 4/18/14, revealed the behaviors (resisting had a goal for stabilify frequency of resistive days. Interventions of medications as presonantidepressant medications as presonantidepressant medications. Review of the 7/23/10 care plan, revealed to Exelon for demonstration of the physician plane patch in same exact spot should be acceptable for the Namenda XR for Trazadone for the worsening depression in the physician plane patch in same exact spot should be acceptable for the Namenda XR for Trazadone for the worsening depression in the physician plane plane plane patch in same exact spot should be acceptable for the physician plane	antidepressant medications by observation period. Inotropic Drug Use CAA (care lated 7/16/15, revealed the ecodon (an antipsychotic phosis. The resident's per routinely reviewed by the consulting pharmacist, and lent had a history of dementia persion, anxiety and plent received Lexapro and persion. In the care plan initiated persident had resistive care and or treatment) and particular particular procession. In the persident had resistive care and or treatment) and persion or decline in the persion per persident had resistive care and or treatment and persions. In the following within the next 90 directed staff to administer cribed, including persions and land report any drug related persion or physician. In the following medications: the following medications: the persion of the proton of the persion. Monitor for	F 428				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		17E531	B. WING _			10/02/2015		
	ROVIDER OR SUPPLIER	cu		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	·			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 428	Continued From pag	ge 69	F 4	28				
	revealed the followind dates: · 2/21/15- Exelor patch topical daily for disturbance. · 12/30/14- Levol mouth (PO) one time hypothyroidism. · 12/30/14- Lexal depressive disorder. · 4/6/15- Trazodo depression. · 2/21/15- Namer dementia with behave the physician saw the and physical. The reto the use of Exelon were not removing to the physical of the physical of the words staff. The physical patch; hower develop worsening is towards staff. The physical at a lower dose behaviors had since the physical of	ing medications with their start in patch 9.5 mg/24 hours 1 or dementia with behavioral shyroxine sodium 75 mcg by the daily for unspecified or 40 mg PO daily for one 50 mg PO at bedtime for onda XR 28 mg PO daily for ovioral disturbances. In note dated 5/8/15, revealed the resident for a yearly history of its incompatible of the patches. Staff noted they he old patch when placing a sician had discontinued the over, the resident began to mappropriate behaviors hysician restarted the Exelon						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E531	B. WING		10/02/2015	
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LTC	ะบ	6	STREET ADDRESS, CITY, STATE, ZIP CODE 507 COURT PL LAKIN, KS 67860	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 428	the medication on the administered it to him headache, diarrhea, physician replied for medications were no Review of the pharm dated: 6/11/15- revealed the incident report regard with two Exelon patcicare staff. 7/11/15- revealed a r Geodon, but it did not identified the omission 8/10/15- revealed no did not identify the fathe resident's Lexaprand trazadone. Observation on 9/30/direct care staff Q gathar and trazadone. An attempt on 9/29/1 resident did not wanted the staff of the medications if the resist of the resident of the staff R reported if the medications in time, emergency medication of town, or from the hospital. Staff R reportal is town, or from the hospital. Staff R reportal is town, or from the hospital. Staff R reportal is town, or from the hospital. Staff R reportal is town, or from the hospital. Staff R reportal is town, or from the hospital. Staff R reportal is to him head to him head to head t	and headache. Staff picked up a afternoon of 8/4/15 and and/her. The resident's and emesis subsided. The staff to make sure the t discontinued again. acist's drug regimen reviews a pharmacist identified and ding staff finding the resident thes on, noted by a direct ecent dose reduction for at indicate the pharmacist on of the drug for 12 days. concerns. The pharmacist cility's failure to administer to, Namenda, levothyroxine, 15 at 8:09 AM revealed we the resident medications in without any issues. 5 at 3:07 PM revealed the at to be interviewed. 2 at one point, the resident did ons for days. Staff R reported face staff member picked up sident really needed them. A facility did not receive the	F 428			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E531	B. WING			10/	02/2015
	ROVIDER OR SUPPLIER	U	•	STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		•	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 428	F 428 Continued From page 71		F.	428			
	his/her medications a occasions.	s ordered on a few					
	should not have gone and the facility neede ensure residents rece ordered. Nurse C rep incidents regarding the administered as well at Exelon patches. On 10/1/15 at 10:01 A was unavailable for in Review of the facility Administration, review when administering metalogical forms and the six rights of the facility of the six rights of the facility and the six rights of the facility of the six rights of the facility of the six rights of the facility and the six rights of the facility of the six rights of the six	C revealed the resident without his/her medications d to work on their process to eived their medications as orted he/she knew of the medications that were not as the incident with the dual AM, Consultant pharmacist X aterview. Policy for Medication wed on 8/2009, revealed medications, staff were to f medication administration medication, route, and the medication in the medication administration medication in the medicat					
	admitted on 8/26/14, including depressive emotional state chara feelings of sadness, vand hopelessness), pdisorder characterized	octerized by exaggerated worthlessness, emptiness sychosis (any major mental d by a gross impairment in exiety (mental or emotional d by apprehension,					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		17E531	B. WING _		,	10/02/2015		
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			•	STREET ADDRESS, CITY, STATE, ZIP CO 607 COURT PL LAKIN, KS 67860		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 428	6/5/15 revealed the reinterview for mental sintact cognition. The symptoms of delirium mood severity score depression. The moor resident had feelings or hopeless, and had asleep, or sleeping to The resident received during the 7-day observation. The Annual MDS dat resident had a BIMS cognition. The resident received a hit resident received a hypnotic resident when staff a some of his/her medii became easily anger received the hypnotic resident was alert an his/her own decisions documentation for the or behavioral sympto. The care plan, review staff if the resident cowere to encourage hit help relax, provide fo head of the bed elevations.	minimum data set) dated esident had a BIMS (brief status) score of 15, indicating resident had no signs or an orall the resident had a total of 3, which revealed minimal and interview revealed the of being down, depressed, trouble falling or staying for much on 1 day or less. It is a hypnotic medication dervation period. Med 9/2/15, revealed the score of 15, indicating intact on the medication during in period. Mug Use CAA (care area and an imal depression. The sypnotic medication during in period. Mug Use CAA (care area and an imal depression. The CAA and attempted a reduction in cations, the resident ed and irritated. The resident ed and irritated. The resident ed and irritated. The resident ed and irritated, and could make as a sleep aide. The doriented, and could make as The CAAs lacked en psychosocial, mood state, mus for the resident. Med on 6/2/15, instructed build not fall asleep, staff milher to watch television to od or drink, and keep the	F4	28				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E531	B. WING _		10)/02/2015	
	ROVIDER OR SUPPLIER	лси		STREET ADDRESS, CITY, STATE, ZIP 607 COURT PL LAKIN, KS 67860			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 428	hypnotic medication depressive disorder Risperdal) (antipsy po (by mouth), 2 ti	age 73 5 for Temazepam (Restoril- a on) 30 mg (mlligrams) daily for er., and Risperidone (vchotic medication), 0.25 mg, mes daily, for psychosis.	FZ	128			
	on the electronic relacked a hypnotic or resident #31. The resident's "Form Medications for the included these me Risperdal 0.25 mg form documented potential risks for the if the resident show medications, the pwith "No, Continuous reasons why so the physician documented by the physician documented in the physician documented in the physician of the physician's associated by the physician's a	ecord revealed the record or sleep assessment for cocused on High Risk e Elderly " form, dated 6/8/15, dications for physician review: and Temazepam 30 mg. The the medications presented a the resident. The form indicated ald continue to receive the thysician should mark the box the, and then indicate the erecords could be updated ". the umented to continue " for the es. " However, the form lacked the sessment of factors related to a dist statement to explain the continued use of these eresident. By AM licensed nursing staff K estered the Restoril for insomnia the asleep and stay asleep). At ated the resident had a					
	have a regular slee the facility failed to for the resident.	o, and that the resident did not ep pattern. Staff K also verified complete a sleep assessment O PM, administrative nursing					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		17E531	B. WING		10/02/2015		
	ROVIDER OR SUPPLIER COUNTY HOSPITAL LTC	ะบ	6	TREET ADDRESS, CITY, STATE, ZIP CODE 07 COURT PL AKIN, KS 67860	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 441 SS=F	staff C, stated Restordepressive disorder, have difficulty with skinursing staff C stated sleep programs were resident #31. On 10/1/15 at 2:01 P unavailable for an int consulting review ind medications had app Review of a Medicati dated 3/2009 reveale would be done in a state of the pharmacist failed identified irregularities review. 483.65 INFECTION CSPREAD, LINENS The facility must estate Infection Control Program and control Program and control Program under which (1) Investigates, continuity facility; (2) Decides what proshould be applied to	ril was not generally given for and stated the resident did eeping. Administrative doeping. Administrative doeping assessments or ecompleted or developed for the completed or developed for the complete diagnosis. In administration policy and medication administration after and orderly manner. In the monthly pharmacist is in the monthly pharmacist or control and the complete environment and development and transmission ion. Program ablish an Infection Control or it complete environment in the complete envi	F 428				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		17E531	B. WING			10/02/2015
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP COD 607 COURT PL LAKIN, KS 67860	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each d hand washing is in- professional practic (c) Linens Personnel must ha	ead of Infection tion Control Program esident needs isolation to of infection, the facility must interpretation to prohibit employees with a case or infected skin lesions with residents or their food, if transmit the disease. It require staff to wash their irrect resident contact for which dicated by accepted	F 44	41		
	This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents. Based on observation, interview and record review, the facility failed to maintain an infection control program to prevent, recognize and control to the extent possible the onset and spread of infection within the facility with the failure to trend infections and antibiotic use, failure to properly sanitize the glucometer, and failure to ensure staff changed oxygen tubing as expected to prevent the spread of infection, for the residents of the facility. Findings included: - Observation, on 9-29-15 at 10:05 am, revealed licensed nursing staff F obtained a blood glucose					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		17E531	B. WING		10/02/2015		
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU				STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	10/02/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
F 441	completion of the test glucometer with an attervity to another unsample obtained a blood glucthe policy was to use glucometer, but thou effective. Interview, on 9-29-15 nursing staff S, reveate wiped off with a Stated 5 residents use. Interview, on 9-30-15 administrative nursing should use the Saning glucometer. The facility policy for dated 12-4-12, from manufacturer, advises surfaces with a blead. The facility failed to sedirected by the manuspread of infection and use this glucometer. - Interview on 9-30-3 staff E, revealed the facility was by culture usage. Staff E stated infections without culflora. Staff E stated resolution of the infections obtained. Staff E	ampled resident. After tt, staff F then wiped the clohol swab and proceeded d resident's room and cose sample. Staff F stated bleach to sanitize the ght alcohol wipes were at 10:30 am, with licensed aled the glucometer should ani wipe to sanitize it and ed this glucometer. at 8:10 pm, with g staff N, revealed staff wipes to sanitize the sanitizing the glucometer, the glucometer ed staff to clean the external	F 44				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E531	B. WING		10/02/2015	
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION	
F 441	Staff E stated there will May, 2015 through A	data at the end of the month. vere no trends identified from	F 44	1		
	revealed: Seven (UTIs)urinary 2015. Nine UTIs in July, 20 Eight UTI in June, 20 Five UTIs in May, 20 Five UTIs in March, 2 Two UTIs in Februar Two UTIs in January Four UTIs in December 10 July 10	tract infections in August, 15. 15. 15. 15. 15. 15. 15. 2015. 2015. 2015. 2014. 5 at 3:00 pm, with g staff C, revealed the facility ary tract infections, chronic cute urinary tract infections, ends as the log filled in by dentify the antibiotic use.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(2	(X3) DATE SURVEY COMPLETED		
		17E531	B. WING _			10/02/2015	
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860			10/02/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIAT	(X5) COMPLETION DATE	
F 441	oxygen tubing, dated oxygen concentrator Interview with the residid not use the oxygen had used it a few night observation, on 9-29 resident #13's oxygen oxygen outlet, and date Interview, on 9-29-15 nursing staff F, reveate be changed every 30 Interview, on 9-29-15 nursing staff W, reveating the oxygen month, and should date Interview, on 9-30-15 administrative nursing expected staff to cha 30 days.	28-15 at 10:14 am, revealed 3-1-15, attached to an in resident # 21's room. ident revealed the resident en often, but thought he/she at 8:45 am, revealed a tubing attached to the ated 5-15-15. at 8:50 am, with licensed led the oxygen tubing should days by the night nurse. at 6:15 pm, with licensed aled the night charge nurse tubing on the first of each ate the tubing.	F 4	.41			
	oxygen tubing. The facility failed to c tubing, as expected,	hange the resident's oxygen every 30 days, to ensure s remained as free from e.	F 5	520			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		17E531	B. WING _			10/02/2015	
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			•	STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	<u>,</u>	10.02.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 520	assurance committee nursing services; a properties of acility; and at least of facility; and at least of facility; staff. The quality assessment committee meets at issues with respect the and assurance active develops and implement of the received in the control of the received in the compliance of such requirements of this. Good faith attempts and correct quality down a basis for sanctions. This REQUIREMENT by: The facility reported Based on observation review the facility fair assurance committee implemented appropagation of the received in the receiver of the received in the facility fair assurance committee implemented appropagation of the received in th	ain a quality assessment and e consisting of the director of obysician designated by the 3 other members of the sent and assurance least quarterly to identify to which quality assessment dities are necessary; and ments appropriate plans of notified quality deficiencies. Letary may not require ords of such committee ord disclosure is related to the committee with the section. By the committee to identify efficiencies will not be used as as as. T is not met as evidenced If a census of 38 residents on, interview, and record led to maintain a quality e that developed and priate plans of action to reactions of quality of care residents. In addition, the committee failed to meet designate and considered to meet designa	F 5	20			
	- Review of the qua	lity assurance committee					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		17E531	B. WING		10/02/2015		
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			•	STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	10/02/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 520	the facility with the re on August 18, 2014, September 28, 2014 Interview, on 9-30-18 administrative nursin assurance committee meetings did not incleacility, so it did not incommittee members Furthermore, the factor manage the facility in needs of the resident resurvey, including: 1) Failure to provide residents as evidence a) Refer to 309. The bruise for 1 (# 31) of the 16 control of the 16 control of the 16 control of the 3 sample for 2 of the 3 sample	evealed the committee for equired facility members met February 13, 2014, and at 4:10 pm, with g staff N, revealed the quality e met monthly but the ude 3 staff from the nursing include the required from the facility. Sility's governing body failed to ma manner to meet the its as evidenced by this quality of care for the ed by the following: If facility failed to monitor a facility failed to review and refor grooming and bathing	F 52				
	provided appropriate	facility failed to ensure staff assessment and re 1 of 2 residents reviewed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		17E531	B. WING		10/02/2015		
	ROVIDER OR SUPPLIER	eu .		STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860	10.022010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION		
F 520	normal bladder funct	e 81 ace maintained as much ion as possible. This failure in bladder continence for	F 52	0			
	residents ' environm accident hazards as ensure the exit doors prevent cognitively in mobile residents fron facility. Per facility re	e facility failed to ensure the ent remained as free of possible by the failure to had a functioning system to appaired, independently wandering outside of the ported 13 residents who aired and independently					
	nutritional services for	facility failed to provide or 2 (#36 and #37), of 3 or weight loss, to prevent					
	5 residents reviewed medications received antihypertensive med	I adequate monitoring for dications, monitoring for PRN ions (#25 and #31), and					
	5 residents reviewed	facility failed to ensure 1 of for unnecessary e of significant medication					
	The facility's quality a	assurance committee failed					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E531	B. WING			10/02/2015	
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU		U		STREET ADDRESS, CITY, STAT 607 COURT PL LAKIN, KS 67860	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 520	. •	s and implement a program	F	20			